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ABSTRACT

Presented is a manual designed to aid social workers and other staff of institutions in dealing with problems of disabled Social Security Administration (SSA) and Supplemental Security Income (SSI) beneficiaries who receive their benefits through representative payees. Information is provided about such topics as different types of benefits, proper use of benefits by representative payees, how to deal with representative payees, and how to become a representative payee. Sections cover the following topics: SSA and SSI disability benefits, general information on representative payees, specific information on payees for institutionalized persons, communication with outside payees, courses of action, and how to deal with the SSA (including sources of legal help). Appended are copies of SSA forms, a list of district offices serving state institutions in Massachusetts, and the names and phone numbers of field representatives for Massachusetts. (IM)

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REPRESENTATIVE PAYEES:

WHAT THEY ARE AND

HOW TO DEAL WITH THEM

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Commission on the Legal and Civil
Rights of the Developmentally Disabled

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June, 1976

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I. INTRODUCTION

This manual is designed to aid social workers and other staff of institutions in dealing with the problems of Social Security beneficiaries who receive their benefits through representative payees. The proper use of these funds is necessary to insure that institution residents receive every possible advantage that they are entitled to.

This manual contains information about the different types of benefits available to residents of institutions and proper use of the benefits by representative payees. In addition, it contains advice on how to deal with "outside" representative payees who may appear to be misusing benefits and with the procedures established by the Social Security Administration (SSA) in such cases.

II. SSA AND SSI BENEFITS

A. What is a disability?

A disabled person is someone who has a severe mental or physical condition which (1) prevents him from working and (2) is expected to last at least twelve months, or is expected to result in death.

B. SSA benefits

Persons over 18 years of age who became disabled before the age of 22 are eligible for SSA Dependent Disabled Child benefits on the account of either of their parents. Also eligible for these benefits are: (1) disabled children under age 18 of disabled or retired workers who are themselves collecting SSA benefits, and (2) disabled children of a deceased wage earner, regardless of the of the age of the deceased parent or the surviving child. Finally, a working person who becomes disabled before he reaches age 65 is eligible for disablility benefits on his own account.

C. Supplemental Security Income (SSI) benefits

A second type of benefit is available to disabled individuals who

are not eligible for SSA benefits. SSI benefits assure a basic cash income for persons who have little or no regular cash income of their own, who have few other financial resources, and who are either blind, aged, or disabled. The amount of the benefit for institutionalized persons is often less than what the person would be eligible for if he lived outside an institution. The type of institution determines how much the SSI payment will be:

INSTITUTION	AMOUNT OF BENEFIT
Private, certified for Medicaid reimbursement of over 50% (converted from welfare to SSI)	No more than $25/month (No more than $30/month)
Private, certified for Medicaid reimbursement of under 50%	Full grant
Private, not certified for Medicaid reimbursement	Full grant
Public, certified for Medicaid reimbursement of over 50%	No more than $25/month
Public, certified for Medicaid reimbursement of under 50%	No money
Public, not certified for Medicaid reimbursement	No money

(From SSI Manual prepared by SSI Advocacy Center)

The benefits - both SSA and SSI - are to be sent directly to the beneficiary unless he has been deemed incapable of managing and spending all of his own funds. If he is found incapable, the benefits are sent to the representative payee selected by the Social Security Districy Office, to be used in the "best interests" of the beneficiary.

III. REPRESENTATIVE PAYEES - GENERAL

A. What is a representative payee?

A representaive payee is a person or organization selected by the SSA District Office to receive and manage payments for a beneficiary who is deemed

incapable of doing so.

B. How to apply to become a representative payee

To apply to become a representative payee, one must complete forms SSA-11, Applicant to be Selected as Payee (Appendix A), and SSA-780, Certificate of Applicant for Benefits of Another (Appendix B). Provided that the applicant exhibits care and concern for the welfare of the recipient, the following hierarchy of preference is usually followed by SSA in selecting a payee:

(1) a legal guardian; spouse (or other relative) who has actual custody or who demonstrates a strong interest in the personal welfare of the beneficiary;

(2) a friend who has custody or who demonstrates strong interest in the personal welfare of the beneficiary;

(3) the superintendent of a public or non-profit agency or institution having actual custody;

(4) a private, profit-making institution having actual custody, if licensed under state law.

(SSA Claims manual transmittal sheet no. 675, Sec. 984, January, 1959)

C. Basic responsibilities of representative payees

In managing the beneficiary's funds, the payee is first responsible for meeting the basic needs of the beneficiary, including food, clothing, shelter, and personal needs such as pocket money if the beneficiary is able to use it. After that, the payee should see to the beneficiary's special needs such as school expenses, rehabilitation and medical expenses, and for other purposes that are in the beneficiary's best interest.

The representative payee is legally required, upon request of the District Office, to account for what he has done with the benefits paid to him on behalf of the beneficiary. (20 CFR 404.1609).

D. Appeal rights and procedures

Drug addicts, alcoholics, and persons legally determined to be incompetent by a probate court, may not appeal the decision to appoint a representative payee, since representative payment on their behalf is legislatively

mandated. (20 CFR 416.601) For all other beneficiaries, the decision to appoint a representative payee is made solely at the discretion of the District Office, as is the selection of the particular representative payee. SSA regulations have no provision for the right to a prior hearing before a representative payee is appointed. This decision is classified as an "initial determination" and is therefore appealable after it has been made. New regulations include the identity of the representative payee as an initial determination. However, only the beneficiary, not the institution staff, has the right to make an appeal.

After an initial determination has been made, there is a five step procedure which persons can use in attempting to change the representative payee. First, a letter must be sent to the local District Office requesting a change of payee. Ordinarily, such a request is ruled upon in six to eight weeks, according to SSA. Second, if this req est is denied, a beneficiary or the beneficiary's representative may appeal for a reconsideration of the initial determination under 20 CFR 404.909 and 416.1410. This appeal must be made within six months of the initial determination for SSA benefits or within thirty days for SSI funds. Third, if the reconsideration judgment is adverse, a hearing before an administrative law judge on the reconsideration may be requested under 20 CFR 404.917 and 416.1425. This request must be made within six months of notice of the reconsidered determination for SSA benefits or within thirty days of such notice for SSI benefits. Fourth, if the hearing results in an adverse decision, an individual may request a review of the decision by the SSA Appeals Council under 20 CFR 404.945 and 416.1461. This request must be made within sixty days of notice of the Administrative Law Judge's decision for SSA recipients or within thirty days of such notice for SSI recipients. Fifth, after these administrative steps have been exhausted, the appeal may be brought to the United States District Court.

IV. REPRESENTATIVE PAYEES - INSTITUTIONAL

A. Procedure for appointment

When the superintendent of an institution is applying to be representative payee, Forms SSA-11 and SSA-780 must be completed and sent to the local SSA District Office. An institution should not apply for a resident if the resident knows the value of money and is capable of managing and spending his own funds.

B. Responsibilities

The superintendent of an institution who becomes representative payee has several unique responsibilities. First, the institution is required to notify the SSA District Office in the case of a resident beneficiary's discharge, death, or any change of custody when it reasonably appears that the change is more than temporary in nature. (DMH Regulations Title IV, Chap. 1, 14.16)

Second, the institution is required to notify the District Office when the beneficiary is employed in other than therapeutic work. If the work is therapeutic, and the beneficiary is receiving wages under the Fair Labor Standards Act, this should also be reported to the SSA. This responsibility continues as long as the superintendent is payee, regardless of whether or not the beneficiary continues to be a resident of that institution.

Third, it is important that the superintendent establish lines of communication between administrative and ward level personnel, to determine what funds are available for the resident and to ascertain the personal needs of the resident.

Fourth, as with all representative payees, the beneficiary's personal needs must be met. The following list includes examples as to how the resident's benefits may be used to enrich his life at the institution. These are only suggestions: the unique circumstances, needs, desires, and resources of the residents should determine priority and importance and appropriateness of each expenditure. The list is by no means exhaustive.

(1) Draperies, pictures, and furnishings for the resident's living area;

(2) Games, books, magazines, cigarettes, tobacco, writing paper, and envelopes;

(3) Insurance premiums;

(4) Legal services;

(5) Living expenses of the resident (e. g. canteen, laundry, or shopping money);

(6) Living expenses of the beneficiary when he is residing away from the institution;

(7) Medical and dental services and supplies which the Commonwealth is not obligated to provide the beneficiary;

(8) Personal clothing;

(9) Radios, televisions, and record players;

(10) Special trips and vacations, including travel expenses;

(11) Storage boxes;

(12) Supplies and articles for personal grooming and care;

(13) Supplies and equipment for occupational therapy such as materials for metal or leather working, needleworking, or furniture-making;

(14) Tutoring or other instruction or counseling;

(15) Group purchases, provided that all clients benefited by them contribute a fair amount towards the purchase and if all clients contributing towards the purchase receive a fair benefit in return;

(16) Supplies, therapy, etc. that facilitate the resident's earliest possible habilitation or rehabilitation and that help the resident lead as normal and comfortable a life as possible; and

(17) Other necessities and personal extravagances which benefit the resident and are consistent with his desires, resources, and obligations.

(DMH Regualtions, Title IV, Chap. 1, Sect. 14.08)

C. Evaluation

Unless a guardian or conservator has been appointed prior to admission, the resident must be evaluated within thirty days of admission to determine his ability to manage and spend his own funds. He should be evaluated at least once thereafter during the first six months after admission and at least once every twelve months throughout his stay in the institution (or upon specific request

of the resident). (DMH Regulations, Title IV, Chap. 1, Sect. 14.05)

D. How to handle patient funds

If the resident has been evaluated and determined to be competent to handle his own funds, then no representative payee should be appointed and the benefits should be sent directly to the resident. If the evaluation finds the resident to be fiscally incompetent, and the superintendent has been appointed as representative payee, then the following procedures should be observed:

(1) The superintendent of the institution bears the ultimate responsibility for the management and spending of these funds. He should designate a staff member of the institution, usually a social worker, who has first-hand knowledge of the resident's day-to-day needs, to be directly responsible to the superintendent and to determine how best to manage and spend the resident's funds. (DMH Regulations, Title IV, Chap. 1, Sect. 14.08)

(2) If the resident's funds at any time exceed $250, no more than $200 of the resident's funds should be kept in a group bank account. The balance must be kept in an individual, interest-bearing account and any interest which accrues belongs to the resident. The account shall be in the resident's name but under the control of the superintendent. (DMH Regulations, Title IV, Chap. 1, Sect. 14.08)

(3) The superintendent should designate one or more persons, called "shoppers" to make purchases for residents who are unable to leave the institution. Shoppers are responsible for purchasing items efficiently and economically. They are accountable for all expenditures they make. Shoppers must make every effort to understand and be responsive to the individual needs and tastes of the resident. They should be aware of contemporary tastes and trends in clothing and furniture. They should maintain catalogues to enable residents to participate in shopping through the selection of individual items, styles and colors. It is very important that the resident's funds do not merely accumulate in his account. The designated staff member should take a common sense approach to these expenditures;

no reasonable purchases will be questioned by the SSA. (DMH Regulations, Title IV, Chap. 1, Sect. 14.13)

(4) A high priority should be given to the training of residents in the management and use of their money. With such training, residents with representative payees may become able to undertake the management and control of their funds. If so, these residents should begin to receive their SSA and SSI benefits directly, relieving the institution of this task and realizing an important habilitation goal. (DMH Regulations, Title IV, Chap. 1, Sect. 14.14)

V. REPRESENTATIVE PAYEE - OUTSIDE

A. Communications with outside payees

Many SSA beneficiaries have representative payees who live outside the institution. It is with these payees that many problems arise concerning non-payment or abuse of benefits. To minimize the risk of representative payee abuse, the staff of the institution should keep in close contact with the outside payee. The representative payee is required, as noted above, to pay whatever care and support that a resident needs which is not covered under the normal institutional budget.

Under SSA regulations, the representative payee is supposed to keep in close contact with the institution to ascertain the beneficiary's personal needs. Oftentimes, this does not happen. Therefore, it is best for the social worker to contact the representative payee to discuss what the beneficiary's needs are. A social worker should develop a plan with the representative payee based on the beneficiary's needs. For example, the social worker might request a $25 allowance to be deposited in the resident's account at the institution each month for personal needs. Also, a regular list of clothing needs should be sent to the representative payee. Clothing may be purchased by the payee, or the payee can arrange to send funds sufficient to pay for the needed clothing.

In addition to routine expenditures, the payee is required to pay

for any special needs the beneficiary might have. For example, special wheelchairs for the multiply-handicapped can and should be purchased from these funds. It is the obligation of the institutional staff to inform the representative payee whenever payments to compensate for special needs are required.

The social worker should encourage the representative payee to visit the beneficiary as often as possible to boost his morale and to help determine what his needs are. A representative payee may use the benefits he receives for reasonable transportation costs involved in visiting the beneficiary.

B. Non-cooperation of outside payees

Where an outside payee ignores the requests for funds or refuses to cooperate with the requests, the SSA District Office should be contacted. If non-cooperation continues after contact with the SSA office or if no response is received from SSA, then a change in the representative payee should be requested. The new payee can be another "outside" individual concerned with the beneficiary's welfare or the superintendent of the institution in which the beneficiary resides.

If the District Office determines for themselves that there has been a misuse of funds, the case will be forwarded to the recovery section of the SSA for restitution of the funds. If the payee who misused the funds refuses to comply with the demands for restitution of these funds, the case will be considered for possible court action. (SSA Claims Manual, Sect. 8452)

VI. HOW TO CHANGE THE REPRESENTATIVE PAYEE

A. It can be done

The first thing that a social worker should know about the changing of a representaive payee is that it can be done. Often this process entails contending with SSA District Office personnel who feel overburdened already with other demands on their time. Do not give up because of apparent disinterest or delay: your clients are counting on you.

When a representative payee refuses to cooperate with requests from a social worker of an institution for increased financial support of a resident, the local SSA District Office should be notified. Often, a complaint will rectify the situation: SSA will contact the representative payee, inform him of his duties as payee, and thereby cause a more favorable response from the payee.

B. Courses of action

If a complaint to the SSA brings no acceptable response, three courses of action are available to the social worker:

(1) Request that the beneficiary be appointed as his own payee. This option would apply, of course, only to those beneficiaries who can manage their own funds. To request that an institutionalized beneficiary receive his own checks, Forms SSA-11, Application to be Selected as Payee (Appendix A), and SSA-787, Medical Officer's Statement (Patient's Capability to Manage Benefits) (Appendix C) must be completed, with the necessary signatures and submitted. If a beneficiary is not institutionalized, Forms SSA-11 and SSA-786, Physician's Statement (Patient's Capability to Manage Benefits) (Appendix D), must be completed, signed, and submitted. Form SSA-780A, Statement of Person with Whom Beneficiary Is Living, (Appendix E) will normally be requested by SSA after receipt of the other forms. Hence, the application may be expedited if this form is sent along with the other forms.

(2) Request that the superintendent of the institution be appointed payee. This is a common procedure for institutionalized beneficiaries and can be very efficient if the institutional staff is sensitive to the resident's needs. Forms SSA-11 and SSA-780, Certificate of Applicant for Benefits on Behalf of Another, (Appendix B) must be completed, signed, usually by the superintendent, and submitted. Again, it is a good idea to also include SSA-780A.

(3) Request that another outside payee be appointed. Despite the problems that may have precipitated the change of payee request, the social worker should consider whether another outside payee may be appointed. An outside

payee who is truly concerned with a resident's welfare can be a tremendous asset for an institutionalized person. To follow this route, Forms SSA-11 and SSA-780 must be completed, signed, and submitted by the person who is requesting the appointment. Form SSA-780A should still be filled out by the institution.

All of the forms are available from the SSA District Office. For convenience sake, it is advisable that the institution keep an inventory of the above-mentioned forms on hand. Also, the local District Office should be able to answer any questions regarding problems concerning the change of payee.

VII. HOW TO DEAL WITH THE SSA

A. Know your local office

In dealing with the SSA, it is quite helpful to get to know the local District Office associated with your institution (Appendices F & G). In some institutions, field representatives have regularly scheduled visits. Otherwise, the social worker should cultivate a working relationship with the local office.

B. The Privacy Act and SSA

The information available to institutional staff from the SSA is limited by the Privacy Act of 1974 (5 USC 552a). Under this law, the identity of the representative payee and any other information from a beneficiary's file is not normally available to institutional social workers. However, a beneficiary may appoint a social worker, or anyone else, as his representative to have access to his SSA file. A sample of a form which may be used by a competent resident to give permission for access to his file is included as Appendix H. Of course, a guardian or conservator may also grant similar access for his ward.

In the future, information about representative payees may be available from SSA as a "routine use" under the Privacy Act. SSA has the power to release information from beneficiary's files for a purpose compatible with the purpose for which it was collected. This avenue of information is not available currently.

C. Other sources of information

The SSA is supposed to send the institution a letter of notification whenever a representative payee is appointed for one of its residents. In addition, they are supposed to periodically send an "audit sheet", SSA-780A, for each resident-beneficiary. This form can serve two useful purposes: (1) it lets the institution know that someone is receiving the resident's benefits and what his name is, and (2) it gives the institution the opportunity to advise SSA as to whether or not the staff feel that the representative payee has misused funds.

Another source of information is Form SSA-827b, General Authorization for Medical Information, (Appendix I). The name of the person on the top line (the signature of claimant or person acting on his behalf) should be noted as it is most certainly the name of the representative payee. This form is received when someone such as a parent initially applies for benefits for a resident.

D. Legal help

This manual has been just a brief summary of the rights of SSA and SSI beneficiaries. Further information may be obtained from the SSI Center, 2 Park Square, Boston, (617) 482-2307.

In some cases, it may be advisable to hire an individual attorney for a resident. Remember that paying lawyers' fees is a legitimate use of SSA or SSI funds. Referral to lawyers interested in these issues may be obtained from your local legal aid organization, the Massachusetts Bar Association Referral Service, (617) 523-0595, or the Mental Health Legal Advisors Committee, (617) 723-2876.

APPENDIX A

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration

Form Approved
OMB No. 72-R0130.

(Do not write in this space)

APPLICATION TO BE SELECTED AS PAYEE

BEST COPY AVAILABLE

NOTICE—Whoever makes or causes to be made any false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act is subject to not more than a $1,000 fine or 1 year of imprisonment, or both.

Print name of wage earner or self-employed person	Enter his Social Security Number
Print name of person or persons entitled to benefits or special age 72 payment *(Herein referred to as the beneficiary)*	Enter his Social Security Number

Print Your Name *(If different from either of the above)*

I hereby request that the social security benefits or special age 72 payments for the beneficiary named above be paid to me. *(If you are requesting that your own benefits or special age 72 payments be made directly to you instead of to someone else on your behalf, answer the questions on this form with respect to yourself.*

1. Explain why you wish payment to be made to you:

2. Is there a legal representative (guardian, conservator, curator, etc.) of any beneficiary for whom you are asking payment?
☐ Yes *(If "Yes", enter below the name, address and telephone number of the legal representative.)* ☐ No

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR:

(a) DEATH of any beneficiary;
(b) MARRIAGE of a person entitled to child's, widow's, mother's, widower's, or parent's benefits; or to wife's benefits as a divorced wife; or to special age 72 payments;
(c) DIVORCE or ANNULMENT of the marriage of a person entitled to wife's or husband's benefits; or special age 72 payments;
(d) CHANGE IN SCHOOL ATTENDANCE of individual between age 18 and age 22 entitled to benefits as a full-time student.

Benefits may end if any of the above events occur. However, there are certain exceptions which are explained in the informational booklet which you will receive. You must report each of these events even if you believe an exception applies. We will advise you whether additional evidence is needed and how the benefits may be affected.

3. Do you agree to notify the Social Security Administration promptly if any of the above events occur, and to return promptly any benefit check you receive to which the beneficiary is not entitled? ☐ Yes ☐ No

FORM SSA-11 (1-72) *(Over)*

Questions 4 and 5 need not be answered for any beneficiary who was age 72 or over in all months of this year and last year, or who is receiving (a) disability insurance benefits (b) disabled widow's or widower's benefits (c) child's benefits as a disabled child age 18 or over

Please read carefully before going on to item 4

Some or all of a person's benefits are not payable if, while under age 72, the person works for more than $175.00 a month in employment or performs substantial services in self-employment in any month, and has earnings in excess of $2,100 for the taxable year. This applies to all employment and self-employment, whether or not covered by the Social Security Act. As an employee, count the gross wages (not the take home pay) earned during the year, regardless of when the wages are paid. As a self-employed person, count the net earnings from business (after deducting allowable business expenses.)

4. (a) Do you expect the total earnings of any beneficiary listed above to be more than $2,100 this year? (Count all earnings beginning with the first of this year and all expected earnings through the end of this year.) ☐ Yes *(If "Yes," answer (b).)* ☐ No

(b) Name of Beneficiary Who Expects To Earn Over $2,100 This Year	Expected Earnings	List Each Month (Including the present month) The Beneficiary Did Not Earn More Than $175 in Employment and Did Not Perform Substantial Services in Self-Employment

An annual report of earnings must be filed with the Social Security Administration within 3 months and 15 days after the end of any year in which any beneficiary earned more than $2,100 if the person was under age 72 at least 1 full month of that year and received some benefit payment for such a month. FAILURE TO REPORT MAY RESULT IN THE LOSS OF ONE OR MORE MONTHLY BENEFITS.

5. Do you agree to file the annual report of earnings when required? . . . . . ☐ Yes ☐ No

Answer Question 6 only if the beneficiary is receiving either (a) disability insurance benefits (b) disabled widow's or widower's benefits or (c) benefits as a disabled child age 18 or over.

REPORT THE FOLLOWING EVENTS FOR DISABILITY BENEFICIARIES

(a) The disabled person's MEDICAL CONDITION IMPROVES, so that he may be able to work, even if he has not yet returned to work;
(b) The disabled person GOES TO WORK, whether as an employee or self-employed person;
(c) The disabled person (or someone on his behalf) applies for, or begins receiving, WORKMEN'S COMPENSATION BENEFITS;
(d) The disabled person (if now hospitalized) is DISCHARGED FROM THE HOSPITAL.

6. Do you agree to notify the Social Security Administration promptly if any of the above events occur? . . . . . ☐ Yes ☐ No

Answer Question 7 only if the beneficiary is receiving special age 72 payments.

REPORT THE FOLLOWING EVENTS FOR SPECIAL AGE 72 PAYMENT BENEFICIARIES:

(a) Beneficiary or spouse becomes ELIGIBLE FOR PERIODIC GOVERNMENTAL PAYMENTS (pensions, annuities, retirement payments, etc.), whether from the Federal government or from the State or local government.

(b) Beneficiary or spouse receives PUBLIC ASSISTANCE cash payments.

(c) Beneficiary or spouse resides outside the 50 states of the U.S. and the District of Columbia.

7. Do you agree to notify the Social Security Administration promptly if any of the above events occur, and to return promptly any benefit check you receive to which the beneficiary is not entitled? . . . . . ☐ Yes ☐ No

Answer Questions 8 through 10 only if you are asking payment on behalf of (a) your natural or adopted child or children or (b) your husband or wife.

8. Is the child (children) or husband or wife for whom you are asking payment now living with you?

☐ Yes *(If "Yes," answer 9 and 10 below)* ☐ No *(If "No," go on to item 11)*

9. Do you understand that all payments made to you on behalf of a beneficiary must be spent for his present needs or (if not presently needed) saved for his future needs and do you agree to use the benefits that way? . . . . . ☐ Yes ☐ No

10. Do you agree to notify the Social Security Administration promptly if any beneficiary leaves your custody, or when you no longer have responsibility for the welfare and care of any beneficiary for whom you are asking payment? . . ☐ Yes ☐ No

TO BE ANSWERED ONLY BY A CLAIMANT FOR MOTHER'S INSURANCE BENEFITS.

If you are the mother asking for payment on behalf of a child or children following the death of the insured individual, answer the following question:

11. Did the child or children live with you in every month since the death of the insured individual?
☐ Yes ☐ No *(If "No," enter the information asked for in the chart below)*

Name of Child	List each month in which that child did not live with you

Remarks: *(This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)*

I know that anyone who makes a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law. I affirm that the above statements are true.

SIGNATURE OF APPLICANT	DATE (Month, day, year)
Signature *(First name, middle initial, last name) (Write in ink)* SIGN HERE ▷	Telephone Number(s) at which you may be contacted during the day
Mailing Address *(Number and street, Apt. no., P.O. Box, or Rural Route)*	
City and State / ZIP Code	Enter Name of County (if any) in which you now live

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, city, state, and ZIP code)*	Address *(Number and street, city, state, and ZIP code)*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

TOE 250 Form Approved. OMB No. 72-R0148

APPENDIX B
CERTIFICATE OF APPLICANT FOR BENEFITS ON BEHALF OF ANOTHER

FOR SSA USE ONLY					
Name or Ben. Sym.	Type	Gdn.	Cus.	Inst.	No-

NOTICE.—Whoever (a) makes or causes to be made any false statement or representation of a material fact for use in determining a right to payment under the Social Security Act, or (b) who, having received a payment for the use and benefit of another person, knowingly and willfully uses such payment for other than the use and benefit of the person for whom it is received, is subject, under the Social Security Act, to a fine of not more than $1,000 or 1 year's imprisonment, or both.

PRINT NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER ___ ___ ___ ___ ___ ___ ___ ___ ___

PRINT NAME OF PERSON FILING THIS APPLICATION *(If different from wage earner)*, AND NAME OF INSTITUTION YOU REPRESENT, IF ANY

In support of my application on behalf of the person or persons named in item 1 below, I hereby furnish the following information and certify that it is true.

NOTE: Please list the names of all the persons for whom you filed application in item 1 below and answer the remaining questions on this certificate with respect to all these persons.

1. **Give the full name of the person (or persons) for whom you filed application.**

2. **Do you represent a bank, social agency, government office or institution?** ☐ Yes ☐ No
(If "Yes," check (√) below which you represent and then go on to item 5. If "No," go on to item 3.)

☐ BANK (or other financial organization) ☐ SOCIAL AGENCY ☐ PUBLIC OFFICIAL (representing government office other than social agency or institution)

☐ MENTAL INSTITUTION *(Check ONE below)*
☐ Federal
☐ State or local ☐ Private non-profit
☐ Private proprietary *(Licensed under State or local licensing law?)* ☐ Yes ☐ No

☐ OTHER *(Specify)*

☐ NON-MENTAL INSTITUTION *(Check ONE below)*
☐ Federal ☐ Private non-profit
☐ State or local
☐ Private proprietary *(Licensed under State or local licensing law?)* ☐ Yes ☐ No

3. **(a) Are you related by blood or marriage to the person named in item 1?** ☐ Yes ☐ No
(If "Yes," check (√) the block below that shows your relationship and then answer item 4. If "No," go on to (b).)

☐ Spouse (husband or wife) ☐ Child (son or daughter) ☐ Stepfather
☐ Father (natural or adoptive) ☐ Grandparent ☐ Stepmother
☐ Mother (natural or adoptive) ☐ Other relative *(Specify)*.....

(b) If you are not related to the person in item 1, indicate why you filed application (for example, friend, legal representative, foster parent, etc.) .....

Also answer item 4 below unless you are applying in your professional capacity, for example, as an attorney or accountant.

4. **(a) Indicate whether you are:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

(b) What is your age?

(c) Are you employed? ☐ Yes ☐ No
(If "No," enter below your main source of support.)

.....

FORM SSA-780 (8-74) *(Over)*

5. (a) Is the person named in item 1 living with you (or in your institution)?
☐ Yes *(If "Yes," answer (b) through (f) unless you are the natural or adoptive parent, or spouse.)* ☐ No *(If "No," go on to item 6.)*

(b) Why is he living with you?.....

.....

(c) Who placed him with you?

(d) When was he placed with you?

(e) How long will he be with you?

(f) If you are not the representative of a financial organization, social agency, government office or institution, does work or other activity take you away from home? ☐ Yes ☐ No

If "Yes," who takes care of the person in item 1 when you are away?.....

6. (a) If the person named in item 1 is not living with you, give the following information:

NAME OF CHILD OR ADULT NOT LIVING WITH YOU	NAME, ADDRESS AND TELEPHONE NUMBER OF PERSON OR INSTITUTION WITH WHOM THE CHILD OR ADULT IS NOW LIVING *(Hereafter this person is called the custodian)*	CUSTODIAN'S RELATIONSHIP TO CHILD OR ADULT	DATE CHILD OR ADULT BEGAN LIVING WITH CUSTODIAN	
			Month	Year

Also give the following information in (b), (c), and (d) about the person named in 6(a) unless you are a public official or the representative of a financial organization or social agency.

(b) Why isn't he living with you? (Omit answer if you are applying in your professional capacity, for example, as an attorney or accountant, and go on to (c) and (d).)

.....

(c) Do you or any other person or agency give money for his support?
☐ Yes *(If "Yes," give the following information.)* ☐ No

NAME OF CHILD OR ADULT	PERSON OR AGENCY CONTRIBUTING, ADDRESS AND TELEPHONE NUMBER. SHOW "SELF" IF YOU ARE CONTRIBUTING.	HOW OFTEN CONTRIBUTIONS ARE MADE	AMOUNTS OF EACH CONTRIBUTION	DATE CONTRIBUTIONS BEGAN

(d) Do you visit the child or adult not living with you, send him clothing or other gifts, write letters, etc.?
☐ Yes *(If "Yes," show below how often you do any of those things.)* ☐ No *(If "No," please explain under "Remarks" how you will find out about the person's needs.)*

NAME OF CHILD OR ADULT	VISIT	SEND CLOTHING	MAKE OTHER GIFTS	WRITE LETTERS	OTHER *(Describe)*

7. **(a) Is there a legal representative (guardian, conservator, curator, etc.) of the property for the person named in item 1?**

☐ Yes *(If "Yes," answer (b) and (c) below.)* ☐ No *(If "No," go on to item 8.)*

(b) Give the legal representative's name, address and telephone number.

NAME OF LEGAL REPRESENTATIVE	ADDRESS OF LEGAL REPRESENTATIVE	Telephone Number

(c) Briefly explain the circumstances which led the court to appoint a legal representative.

.....

8. **(a) Does the person named in item 1 have any outstanding debts or obligations in excess of $100?**

☐ Yes *(If "Yes," answer (b) below.)* ☐ No

(b) Do you plan to use any of the benefits to pay such debts? ☐ Yes ☐ No

If "Yes," show name of creditor(s) you will pay and present amount of the debt(s):

.....

.....

Answer question 9 if you are filing for a child's benefit for a person who is under age 18, or age 18 to 22 and attending school, and you are not the natural parent or adoptive parent.

9. **(a) Does the child for whom you are filing have a living parent?**

☐ Yes *(If "Yes," answer (b), (c), and (d).)* ☐ No *(If "No," go on to item 10.)*

(b) Give the parent's name, address and telephone number.

NAME OF PARENT	ADDRESS OF PARENT	Telephone Number

(c) Does the parent show interest in the child? ☐ Yes ☐ No

Explain your answer .....

.....

(d) Why do you wish to have benefits paid to you instead of to the parent named above?

.....

Answer question 10 if you are not a close relative of the person for whom you are filing.

10. **(a) Does the person for whom you are filing have a close relative?**

☐ Yes *(If "Yes," answer (b), (c), and (d).)* ☐ No *(If "No," go on to item 11.)*

(b) Give the name, address and telephone number of this relative and his relationship to the child or adult.

NAME OF RELATIVE	ADDRESS OF RELATIVE	Telephone Number	Relative's Relationship to Child or Adult

(c) Does this relative show interest in the child or adult? ☐ Yes ☐ No

Explain your answer .....

.....

.....

(d) Why do you wish to have benefits paid to you instead of to the close relative named above?

.....

(Over)

Complete the rest of this certificate in all cases.

11.	Do you understand that all payments made to you on behalf of the person named in item 1 must be spent for his present needs or (if not presently needed) saved for his future needs and do you agree to use the benefits that way?	☐ Yes	☐ No
12.	Do you agree to give the Social Security Administration periodic written reports accounting for your use of benefits, if requested to do so?	☐ Yes	☐ No
13.	If you are selected as payee, what will you do with the benefits? *(Please specify)*		
14.	Do you agree to notify the Social Security Administration promptly when you no longer have responsibility for the welfare and care of any person for whom you receive payment?	☐ Yes	☐ No
15.	*(a)* If the person named in item 1 is now living with you, do you agree to notify the Social Security Administration promptly when he is no longer living with you?	☐ Yes	☐ No
	(b) If the person named in item 1 is living with someone else or living alone, do you agree to notify the Social Security Administration promptly if he goes elsewhere to live?	☐ Yes	☐ No

A beneficiary's entitlement to benefits ends with *the month before the month* in which the beneficiary dies.

16.	Do you agree to notify the Social Security Administration promptly if the beneficiary dies and to return any check you receive on the beneficiary's behalf for the month in which death occurs and any later months?	☐ Yes	☐ No

REMARKS: *(This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)*

I know that anyone who makes a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law. I affirm that the above statements are true.

SIGNATURE OF PERSON COMPLETING CERTIFICATE

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year)*
SIGN HERE ➧	Telephone Number

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	ZIP Code	Enter Name of County (if any) in which you now live

Witnesses are required ONLY if this certificate has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State, and ZIP Code)*	Address *(Number and street, City, State, and ZIP Code)*

☆ U.S. GOVERNMENT PRINTING OFFICE: 1974—584-921/154 2-1

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

TOE 250

Form Approved.
OMB No. 72-R0155

APPENDIX C

This form requests information to help us decide whether any Social Security benefits that may be due should be paid directly to the patient named below or to someone else on the patient's behalf. Your cooperation in completing and returning this statement promptly will be appreciated. Please answer all items as completely as possible; if you need more space you may use the reverse of this form. For your convenience, we have enclosed an envelope requiring no postage.

In replying, Address: SOCIAL SECURITY ADMINISTRATION:	
TELEPHONE	DATE
AUTHORIZED SSA OFFICIAL	

IDENTIFYING INFORMATION *(To be completed by Social Security Administration)*

PATIENT'S NAME	DATE OF BIRTH
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from patient)*	SOCIAL SECURITY NUMBER

MEDICAL OFFICER'S STATEMENT *(Patient's Capability to Manage Benefits)*

1. DIAGNOSIS OF PRESENT CONDITION

2. HOW LONG HAS THE CONDITION EXISTED?	3. WHEN WAS THE PATIENT ADMITTED TO YOUR INSTITUTION?	4. PROGNOSIS

5. (a) IS THE PATIENT PRESENTLY CONFINED IN YOUR INSTITUTION? ☐ YES ☐ NO
(If "Yes," answer (b); If "No," answer (c)):

(b) IF THE PATIENT IS PRESENTLY CONFINED, DO YOU EXPECT TO RELEASE THE PATIENT FROM YOUR INSTITUTION WITHIN THE NEXT YEAR? ☐ YES ☐ NO

(c) IF THE PATIENT HAS BEEN RELEASED, PLEASE GIVE THE DATE THE PATIENT WAS LAST EXAMINED WHETHER AS AN INPATIENT OR OUTPATIENT. — _____ *(Date)*

6. IN YOUR OPINION, IS THE PATIENT ABLE TO MANAGE BENEFIT PAYMENTS IN THE PATIENT'S OWN INTERESTS? ☐ YES ☐ NO

(Whether or not the patient is able to sign the checks is not controlling. The patient must be able to use them or direct their use for the patient's own well-being.)

7. PLEASE GIVE THE NAME, ADDRESS, AND RELATIONSHIP OF THE PERSON OUTSIDE THE INSTITUTION WHO HAS ASSUMED RESPONSIBILITY FOR THE PATIENT OR WHO DISPLAYS AN ACTIVE INTEREST IN THE PATIENT'S WELFARE:

NAME OF PERSON	ADDRESS
RELATIONSHIP TO PATIENT	

I hereby certify that the above statements and answers are true to my best information, knowledge, and belief.

SIGNATURE OF MEDICAL OFFICER (INCLUDES ANY PHYSICIAN ATTACHED TO THE INSTITUTION)	TITLE	DATE

FORM SSA-787 (9-74)

☐ ADDITIONAL INFORMATION ENTERED ON REVERSE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

TOE 250

Form Approved.
OMB No. 72-R0154

APPENDIX D

This form requests information to help us decide whether any Social Security benefits that may be due should be paid directly to the patient named below or to someone else on the patient's behalf. Your cooperation in completing and returning this statement promptly will be appreciated. The information is requested on behalf of the patient without expense to the United States Government. Please answer all items as completely as possible; if you need more space, you may use the reverse side. For your convenience, we have enclosed an envelope requiring no postage.

In replying, Address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE | DATE

AUTHORIZED SSA OFFICIAL

IDENTIFYING INFORMATION *(To be completed by Social Security Administration)*

PATIENT'S NAME	ADDRESS OF PATIENT
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from patient)*	SOCIAL SECURITY NUMBER

PHYSICIAN'S STATEMENT *(Patient's Capability to Manage Benefits)*

1. DIAGNOSIS OF PRESENT CONDITION

2. HOW LONG HAS THIS CONDITION EXISTED?	3. HOW LONG HAS THE PATIENT BEEN UNDER YOUR CARE?
4. WHEN DID YOU LAST EXAMINE THE PATIENT?	5. PROGNOSIS

6. IN YOUR OPINION, IS THE PATIENT ABLE TO MANAGE BENEFIT PAYMENTS IN THE PATIENT'S OWN INTERESTS? ☐ YES ☐ NO

(Whether or not the patient is able to sign the checks is not controlling. The patient must be able to use them or direct their use for the patient's own well-being.)

7. IF YOU KNOW WHO HAS ASSUMED RESPONSIBILITY FOR THE PATIENT OR WHO DISPLAYS AN ACTIVE INTEREST IN THE PATIENT'S WELFARE, PLEASE GIVE THAT PERSON'S NAME, ADDRESS, AND RELATIONSHIP TO PATIENT:

NAME OF PERSON	ADDRESS
RELATIONSHIP TO PATIENT	

8. REMARKS

☐ SEE REVERSE FOR ADDITIONAL REMARKS

I hereby certify that the above statements and answers are true to my best information, knowledge and belief.

SIGNATURE OF PHYSICIAN	TITLE	DATE
▶		

FORM SSA-786 (9-74)

APPENDIX E

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
Budget Bureau No. 72-R0871

The applicant named in block (A) below has filed as representative payee to receive and use the social security benefits due the beneficiary named in block (B). The information requested below is to ascertain the current responsibility assumed by the applicant and the concern he (she) is showing in the beneficiary's overall personal well-being. A postage paid envelope is enclosed for your use. If you have any questions, the social security office shown below will be glad to assist you.

NAME AND ADDRESS OF CUSTODIAN

In replying, Address: SOCIAL SECURITY ADMINISTRATION

Telephone | Date

District Manager

Wage Earner's Name (*If different from beneficiary*) | Social Security Claim Number

A. Applicant's Name and Address | B. Beneficiary's Name and Date of Birth

STATEMENT OF PERSON WITH WHOM BENEFICIARY IS LIVING

NOTE: Please answer all questions. Most may be answered by checking the applicable block after the question.

1. (a) Who placed the beneficiary with you?

☐ Applicant ☐ Other (*Please show name and address below*)

Name

Address

(b) Is the beneficiary now living with you or in your institution?

☐ Yes (*If "Yes," go on to item 2.*) ☐ No (*If "No," answer (c) and (d) below*)

(c) Show the date the beneficiary left your home or institution | Month, Day, and Year

(d) Into whose care (including self-care) was the beneficiary released?
Name:

Where is the beneficiary now residing?
Address: _____

FORM SSA-780A 15-701 (Over)

2. (a) Please show the approximate amount you charge each month to provide for the beneficiary's room, board, and care. $_____ per month

(b) How much of the amount shown in (a) above did (or does) the applicant pay each month?

$_____ per month

(c) Does (or did) any person or agency other than the applicant pay toward the cost of the beneficiary's care and maintenance shown in question 2(a)?

☐ Yes *(If "Yes," please show name and address of other person (including welfare agency) who contributes and the approximate amount, monthly.)* ☐ No

NAME AND ADDRESS	AMOUNT PAID EACH MONTH
	$
	$
	$

3. (a) Did the applicant visit the beneficiary at your home or institution within the past 3 months?

☐ Yes ☐ No

(b) Where the beneficiary has been in your home or institution for a year or longer, please show how often the applicant visited the beneficiary in the past year.

☐ At least 4 times ☐ Less than 4 times ☐ Never visited

(c) Did the applicant contact you or your staff within the past 3 months to ascertain the personal needs of the beneficiary?

☐ Yes ☐ No

(d) Did the applicant provide for the beneficiary's personal needs, such as spending money, clothing, eyeglasses, medical or dental treatment, etc.

☐ Yes ☐ No

4. (a) Does the beneficiary have any unmet personal needs at this time?

☐ Yes *(If yes, please list the needs in (b) below.)* ☐ No

(b) _____

_____

_____

5. In emergency situations, where beneficiary needs surgery, becomes seriously ill, etc., whom would you notify?

☐ Applicant ☐ Other *(Please show name and address of this person or agency below.)*

Name

Address

Signature	Title	Date

☆ U.S.Government Printing Office:1974—545-522/618 2-1

APPENDIX F: District Offices Serving State Institutions

STATE INSTITUTION	LOCAL SSA DISTRICT OFFICE
Belchertown State School	Holyoke
Boston State Hospital	Dorchester
Cushing Hospital	Framingham
Danvers State Hospital	Lynn, Haverhill
Fall River Mental Health Center	Fall River
Gardner State Hospital	Fitchburg, Gardner
Hathorne Regional Center	Lawrence, Beverly, Peabody, Lynn
Dr. Harry C. Solomon Mental Health Center	Lowell
Medfield State Hospital	Norwood
Metropolitan State Hospital	Waltham
Monson State Hospital	Springfield
Northhampton State Hospital	Holyoke
Paul A. Dever State School	Taunton
Rutland Heights Mental Health Rehabilitation Center	Worcester
Taunton State Hospital	Taunton
Walter E. Fernald State School	Cambridge
Westborough State Hospital	Worcester
Worcester State Hospital	Worcester
Wrentham State School	Attleboro

APPENDIX G: Field Representative and Phone Numbers

DISTRICT OFFICE	TELEPHONE NUMBER	FIELD REPRESENTATIVES (OR PERSONS TO CONTACT)
Attleboro	(617) 222-0273	Lester Thurber, Marion Egan
Beverly	(617) 744-2366 (Salem)	No Name
Cambridge	(617) 491-5001	Edward Burns, James Duby
Dorchester	(617) 288-3900	Larry Donnelly
Fall River	(617) 675-1981	Donald Flynn
Fitchburg	(617) 345-4183	Percy Daley
Framingham	(617) 875-6191	Edward Lynch
Gardner	(617) 632-7856	Percy Daley (from Fitchburg)
Haverhill	(617) 375-5619	Thomas Cameron
Holyoke	(413) 534-7361	Samuel Hatch
Lawrence	(617) 686-6171	Mr. Kingston
Lowell	(617) 454-9151	Ethel Eliopoulos
Lynn	(617) 599- 6332	Rick Lee
Norwood	(617) 762-8510	Sumner Steinberg
Peabody	(617) 744-2366 (Salem)	No Name
Springfield	(413) 785-1625	Thomas Kucab, Robert Pease
Taunton	(617) 823-5116	James Donahue
Waltham	(617) 894-4890	Walter Carew
Worcester	(617) 791-2251	Walter Donovan, Robert Igoe

APPENDIX H: Sample Consent Form for SSA Record Access

TO WHOM IT MAY CONCERN:

I hereby appoint _____

of _____ as my authorized representative to have access to inspect and copy all my Social Security and Supplementary Security income documents, claims, records, and files which are under the control of the Social Security Administration. This consent is not a one time only transfer, and is valid for the full ninety (90) day period allowed by the Administration.

Signed: _____

Date: _____

APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved.
OMB No. 72-R0864

GENERAL AUTHORIZATION FOR MEDICAL INFORMATION

I hereby authorize any physician, hospital, agency or other organization to disclose to the Social Security Administration or to the State agency that may review my application for disability benefits under the Social Security Act, any medical records or other information about my disability.

SIGNATURE OF CLAIMANT *(Or person acting on his behalf)* _____ *(Date)* _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE _____

Name and Social Security Number of Wage Earner *(Please print or type)* _____

IDENTIFYING INFORMATION FOR HOSPITALS	a. ADMISSION DATE(S)	b. DISCHARGE DATE(S)	c. *(Give any necessary additional data such as Bldg., clinic, patient no., etc.)* ☐ IN-PATIENT ☐ OUT-PATIENT
	d. BIRTH DATE		e. NAME AND ADDRESS AT TIME OF ADMISSION *(If different)*

FORM SSA-827b (10-71)